

Tracheostomy Tube Failure

TO THE EDITOR: Intermittent or complete tracheostomy tube obstruction secondary to excessive submandibular adipose tissue is not rare in the tracheotomized sleep apnea patient. The article by Rodman and Martin in the July issue¹ described the use of long tracheostomy tubes fashioned from endotracheal tubes to bypass the obstructing tissue. We have used similarly designed tubes but patients often find the long external portion uncomfortable. Additionally, patients with extensive submandibular and neck soft tissue and tracheostomies frequently have difficulties with hygiene, and intertrigo and skin breakdown may develop.

In patients who did not tolerate these special tracheostomy tubes, we have surgically removed the excess, obstructing tissue. A submental lipectomy in a tracheotomized patient with sleep apnea involves making a horizontal apron incision approximately 3 to 4 cm above the stoma. Submental fat and an ellipse of skin are removed. Morbidity is minor and enough soft tissue can be removed to eliminate the obstruction.

Of course, other sources of obstruction should be investigated in a patient with sleep apnea who fails to improve with a tracheostomy. However, submental lipectomy should be considered when the source of obstruction is redundant submandibular tissue.

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TO THE EDITOR: The article by Rodman and Martin on "Tracheostomy Tube Failure in Obstructive Sleep Apnea" in the July issue¹ is an important contribution to the problem of apnea control. The authors' physiological studies are thorough and their mechanical approach to solve tube failures is novel. However, they leave the sleeping position of their patients—a salient feature of clinical observation—unreported. It is known that people with hypopnea and apnea, like most snorers, change their positions and end up on their backs while asleep. Then they snore. Monitoring of the position is indeed crucial.

This is to call readers' attention to a simple clinical step, originally meant to discourage the snorers—the apnea candidates—from sleeping flat on their backs: Insert half of a soft, spongy rubber ball, which is available in any toy shop, in a little mid-dorsum pocket to be attached to the back of the sleepwear. Some may prefer a 5- by 8-cm firm cushion, 4 cm thick. This serves to forestall snoring and to reduce its long-term risk.

I suggest that Drs Rodman and Miller add the "snore ball" to their clinical sleep testing and to record their patients' recumbencies as part of their sleep patterns.

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Soviet Health Care

TO THE EDITOR: In Dr Friedenberg's interesting article, "Soviet Health Care System," in the August issue,¹ he stated that "medical intensive care units, hemodynamic monitoring, vascular and microsurgical techniques and computerized diagnostic modalities—to name a few—have not become a routine part of Soviet medical care."

During my first visit to the Soviet Union in 1969, through the courtesy of A. A. Vishnevski, a vascular surgeon well recognized in the western world, I had the opportunity of observing at least one vascular surgical procedure in Moscow—the replacement of an abdominal aortic aneurysm by a synthetic bifurcation graft. The prosthesis and its use were comparable to the vascular surgery methods in this country.

My second trip to the Soviet Union, with a Harvard alumni group in 1984, included a visit to a cardiovascular surgery institute in Moscow where coronary bypass as well as surgery for congenital heart defects were performed. The monitoring equipment at that institution was advanced and sophisticated, comparable to the best in the United States.

It does not seem likely that the physicians in Leningrad are completely ignorant of what is being achieved in Moscow, less than 400 miles away. More than ten years ago there were, in addition to Dr Vishnevski, two members of the International Cardiovascular Society in Moscow, two in Leningrad, one in Kiev and one in Novosibirsk, Siberia.

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Fear of the Unknown

TO THE EDITOR: I appreciated the article, "Fear of the Unknown," by E.R.W. Fox, MD, in the June 1987 issue.¹ I was particularly interested in his comments about undue fear of radiation from nuclear power plants. I might point out that there was an excellent article in the March 1983 issue by William R. Hendee, PhD, entitled "Real and Perceived Risks of Medical Radiation Exposure."² It includes a graph that shows the real and perceived risks of smoking, motor vehicles, electric power, swimming and x-rays, as compared to nuclear power, by several different groups. It was interesting to note that the fear of nuclear power far outstripped any risks as yet demonstrated, even with the Chernobyl disaster. Perceived risks for all the other factors were greatly underestimated by nearly all groups.

An article in the March 1986 *Reader's Digest* points out the high level of radioactivity associated with smoking tobacco. Tobacco smoke contains both lead 210, which has a weak β -radiation and a long half-life of more than 20 years, and, more important, polonium 210, which emits ionizing α -radiation. In the April 24, 1987, issue of the *Journal of the American Medical Association*, there is an interesting letter from Hebrew University in Jerusalem, pointing out that a smoker may be exposed to as much as 7 mrem of radiation per cigarette.³ They predicted four extra cancer deaths in the